WELCOME TO HOWELL FAMILY CARE!

Today's Date: _____ Soc.Sec#_____ Date of Birth: _____

Last Name: _____ First Name: _____ Middle Initial:_____

Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email:_____ Who can we thank for referring you? _____

GENDER: □Female □Male

MARITAL STATUS: □Single □Married □Divorced □Widowed

PREFERRED LANGUAGE: □English □ French □German □Japanese □ Mandarin □Russian
□Spanish □Arabic □Other_____

RACE: □White □Native American □Asian □Black or African American
□Native Hawaiian or Other Pacific Islander □Prefer to not answer □Other_____

ETHNICITY: □Hispanic or Latino □Non-Hispanic or Latino □Prefer not to answer

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INS. Subscriber: _____**DOB:** _____ **SSN:**_____

Insurance Company: _____**Subscriber ID**: _____**Group#**:_____

Employer: _____ **Business Phone** _____

In case of an emergency, whom should we contact? _____

Relationship to patient? _____ **Phone #**: _____

I hereby authorize payment directly to Howell Family Care of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____ **Date**: _____

Howell Family Care
Sheryl M. Simpson, D.O.
1225 West Grand River Avenue Suite 300
Howell, MI 48843

PATIENT HISTORY

Patient's Name:_____ **DOB:** _____ **Date:** _____

Briefly describe what problem brought you to the doctor: _____

_____

List All Your Medications (Including the dosage, frequency, and any non-prescription medications or supplements you take)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Medication Allergies
1._____
2._____
3._____
4._____
5._____

Past Medical History: Please place a check mark if you or your family have ever had any of the following:

1.Diabetes:	You□ Family□	6. Psychiatric Problem:	You□ Family□	12. Heart Disease:	You□ Family□
2.Thyroid:	You□ Family□	7. High Blood Pressure:	You□ Family□	13. Liver Function:	You□ Family□
3.Seizures:	You□ Family□	8. Lung Disease:	You□ Family□	14. Kidney Disease:	You□ Family□
4.T/B:	You□ Family□	9. Kidney Stones:	You□ Family□	15. Urine Infection:	You□ Family□
5. Cancer:	You□ Family□	10. Bleeding Problems:	You□ Family□	16. Infertility:	You□ Family□
What type of Cancer:		11. Anesthesia Problems	You□ Family□		

_____

Past Gynecological History: 1. Last Mentrual Period _____ 2. #of Pregnancies____ 3. #Live Births_____

Past Surgical History:

Surgery	Date	Surgery	Date
1._____		5._____	
2._____		6._____	
3._____		7._____	
4._____		8._____	

Social History

Family Medical History:

				Disease or Cause of Death
1. Father	Age____	Living □	Deceased □	_____
2. Mother	Age____	Living □	Deceased □	_____
3. Brother	Age____	Living □	Deceased □	_____
4. Brother	Age____	Living □	Deceased □	_____
5. Sister	Age____	Living □	Deceased □	_____
6. Sister	Age____	Living □	Deceased □	_____

□ Single □Married
□ Divorced □Widowed
Do you have or have you ever used tobacco products?_____
If yes, how much? _____
If quit, when? _____
Occupation:_____
Religion: _____

When did you have your last Colonoscopy_____ **Mammogram**_____ **Pap Smear** _____
Immunizations: Last Tetanus Shot? _____ **Pneumonia Vaccine?** _____ **Flu Shot?**_____
If a child, are immunizations up to date? Yes or No

Review of Symptoms

Do you now or have you recently had problems with any of the following?

(Please **Circle** Your Answer)

G/U SYSTEM:	Pain or burning with urination Kidney Stone Frequency Slow or Small Stream Blood in Urine Getting up at night to urinate Leaking of Urine URGENCY Poor Bladder Emptying Recurrent Urine Infections (UTI) Abnormal Vaginal Bleeding Sexual Problems Menstrual Problems
GENERAL:	Change in weight Fever
SKIN:	Lump or Nodules Breast Lump Rashes Sores Other Skin Problems
EYES:	Glaucoma Cataracts Glasses Other Eye Problems
ENT:	Trouble Swallowing Nose Bleeds Dentures Skin Problems Earaches
HEME/LYMPH:	Swollen Nodes or Glands Bleeding Problems Anemia Other Blood Disorders
C/V:	Irregular Heart Beat Heart Failure Angina Heart Valve Problem Heart Murmur Pain in Legs with Exertion Chest Pain Phlebitis Swelling in Legs Blood Clots Other Heart/Blood Vessel Problems
RESPIRATORY:	Shortness of Breath Wheezing Cough Asthma Other Lung Problems
GASTROINTESTINAL	Gall Bladder Problems Blood in Stool Diarrhea Dark Tarry Stools Intestinal Bleeding Poor Appetite Hiatal Hernia Ulcer Indigestion Hemorrhoids Constipation Vomiting Nausea Hernia
NEURO:	Loss of Consciousness Headaches Strokes Dizziness Paralysis Numbness Weakness
PSYCH:	Other Psychological Problem Depression Anxiety
MUSCULOSKELETAL:	Joint Replacement Surgery Broken Bones Gout Arthritis Bone or Joint Pain
ENDOCRINE:	Heat or Cold Intolerance Hot Flashes Flushing Abnormally Thirsty Changes in Body Hair Skin Pigmentation Changes

Do you have any other problem you want to discuss with the Doctor? Yes □ No □

_____ _____

Patient's Signature **Physician's Signature**

Rev. 11/10/15

Howell Family Care, PLLC

Sheryl M. Simpson, DO • Rita Erickson, NP • Fred Keys, NP

PATIENT - PHYSICIAN AGREEMENT

Dear Patients,

We are continuously working on ways to improve how we provide care by updating our technology and performance. We are asking you to improve your health by taking an active role in your health care. We will be asking you to identify your life goals and establishing care management plans, including clearly identified self-management goals and responsibilities.

We trust you, as our patient to:

- Tell us what you know about your health and illnesses, and what your needs and concerns are.
- Take an active part in planning your care and following that plan. Inform us if you are unable to meet your goals.
- Tell us what medication you are taking, and to take your prescribed medication as directed. To ask for refills in a timely manner so there are no lapses in medication dosing. Ask for refills at the time of your visit. To keep us informed when you see other doctors and what medications they prescribe for you or if changes have been made.
- Learn about wellness and prevention: seek our advice before seeing other physicians.
- Keep your appointments, know your insurance, and what it covers. We expect you to pay your share of the visit when seen in the office.

We as your physician will:

- Provide safe, quality care, to you when needed, with respect to you and your privacy. We will not share your medical information without your permission.
- Provide 24 hour access to our health care team via pager or answering service.
- Help you plan goals that meet your needs, and discuss these goals with you to improve your health and help prevent persistent health problems.
- Discuss the most appropriate tests and procedures you need to meet goals, and coordinate your care among other health care professionals.
- Tell you about health and illnesses in a way you can understand, and provide care for short or long term illnesses and give advice to help you stay healthy.

Patient Name (Print) _____ DOB _____ Date_____

Patient Signature _____ Physician Signature _____

Howell Family Care, PLLC

FINANCIAL POLICY

We are dedicated to providing kinder, gentler medical care for you, and we want you to completely understand our financial policies. Please read this thoroughly and sign at the bottom.

1. **PAYMENT IS DUE AT THE TIME OF SERVICE**, This includes deductibles, co-payments and balances. **These must be paid in full before seeing the provider. If you are unable to make payment at time of service, your appointment will need to be rescheduled until payment is made in full.** We accept Visa, MasterCard, Discover, American Express, Debit Cards with the Visa or MasterCard logo, checks and cash.

2. Keep in mind that your insurance policy is a contract between you and your insurance company. **As a service to you, we will file your insurance claim**, if you assign the benefits to the doctor – in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to collect the payment **from you**. If we later receive a check from your insurer, we will promptly refund overpayment you have made.

3. We have made **contractual agreements** with many insurance companies and health plans to accept an assignment of benefits. We are required to obtain your insurance information and establish your ID as the covered person (this is why we copy your insurance information and driver's license). We will bill them, and **you are required to pay deductibles and/or co-payments at the time of your visit.**

4. **If you are insured by a plan that we do not have agreements with,** we sometimes may be able to prepare and send the claim for you on an unassigned basis. This means the insurer will send any payment directly to you. Therefore, **our charges for your care are due at the time of service.** Note: Some plans will not cover "out of network" services or treatments by a physician not your chosen PCP (PRIMARY CARE PROVIDER) whatsoever, so please be familiar with your plan and your coverage.

5. Not all insurance plans cover all services. **In the event your insurance plan determines a service to be "NOT COVERED," you will be responsible for the entire amount due**. Payment is due upon receipt of a statement from our office.

6. **PATIENTS WHO MISS THEIR SCHEDULED APPOINTMENT, OR LATE CANCEL, LESS THAN 24 HOURS NOTICE, WILL BE RESPONSIBLE FOR A "NO SHOW" FEE. Established patients, who do not show up for a scheduled appointment less than 24 hours prior to appointment, there will be NO FEE for the *first* occurrence, however there will be a fee of $35.00 for the second occurrence, and a fee of $50.00 for subsequent occurrences, payable prior to seeing the doctor.**

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or responsible party, if minor) Date

_____ _____

Please print the name of the patient Date of Birth

COMMUNICATION OF RESULTS

I understand that any information in regards to the treatment of my health care will not be released to anyone other than whom I have listed below. I grant permission to the staff of Howell Family Care to communicate any information and or test results in the following manner, circle **all** that are acceptable.

1. ONLY TO ME

2. To my spouse or otherwise designated person(s) listed below:

   _____

   _____

3. On my home answering machine or voicemail

4. On my cell phone/voicemail

5. The number I prefer to be reached at : _____

_____
Please print your name

_____ _____
Please sign here Date

RECEIPT OF NOTICES OF PRIVACY PRACTICES

I, _____, have been offered the opportunity to read Notice of Privacy Practices, located on the practice waiting room/front office counter. A written copy of the notice is also available upon request.

_____ _____
Please sign here Date

Howell Family Care, PLLC

Patient Responsibility Agreement for Controlled Substance Prescriptions

We, at Howell Family Care, are committed to doing all we can to treat your medical needs. In some cases, narcotics are used as a therapeutic option in the management of chronic pain, ADD/ADHD, or other medical diagnoses. The use and distribution of these narcotics is strictly regulated by both state and federal agencies. The success of treatment depends on the mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits of using controlled substances.

- You may only use one provider to prescribe and monitor all controlled substances.
- All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies; our office must be informed immediately. **The pharmacy you have selected is:** _____.
- You should inform your provider of all medications you are taking including herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
- You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. You are to take medications as prescribed. Refills will be made only during regular office hours, in person. Refills will not be made at night, weekends or during holidays.
- You are responsible for keeping your medication in a safe and secure place, such as locked in a cabinet or safe. Stolen medication should be reported to the police and to your physician immediately. Lost or stolen medication will not be filled.
- The use of alcohol and controlled substance is not advised.
- You agree and understand that your provider reserves the right to perform random or announced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your provider may change your treatment plan, including safe discontinuation of your controlled substances when applicable or complete termination of the provider/patient relationship.
- You further understand that if you violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, you may be subject to dismissal from this facility.
- Any evidence of drug hoarding, acquisition of any controlled substances from other physicians, uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the provider/patient relationship.
- You also agree to a family conference or a conference with a close friend or significant other, if the provider feels it is necessary.
- You agree to allow your provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions, if the provider feels it's necessary.

I understand that if I violate any of the above condition, my prescription for controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

I have read this agreement and the same has been explained to me by Howell Family Care staff. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled and/or discharge from Howell Family Care.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Physician Signature: _____.